NC DMA Pharmacy Request for Prior Approval - Kalydeco

Recipient Information **DMA-3484**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____

Requester Contact Information

Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **Kalydeco** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

1. Does the beneficiary have a diagnosis of Cystic Fibrosis? ☐ Yes ☐ No
2. Is the beneficiary age 6 or greater? ☐ Yes ☐ No
3. Does the beneficiary have a documented G551D mutation in the CFTR gene? ☐ Yes ☐ No
   (Documentation must accompany this prior approval request)
4. Is the total daily dose prescribed 300mg/day total or less? ☐ Yes ☐ No
5. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? ☐ Yes ☐ No

Please list ALT and AST results and date labs were done.

_____

_____

_____

_____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp V.01